DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

2001 SEP 21 P 4:04

1. TRANSMITTAL NUMBER:	2. STATE:
0 1 — 0 1 5	MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 - 272

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 90,780,942
b. FFY 2002 $ 98,298,008

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19 D Pages 1-63

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19 D Pages 1-57

10. SUBJECT OF AMENDMENT:
Nursing Facility Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Single State Agency Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gail Gray

13. TYPED NAME:
Gail Gray

14. TITLE:
Director

15. DATE SUBMITTED:
September 17 2001

16. RETURN TO:
Department of Public Health and Human Services
Gail Gray Director
Attention Kelly Williams
P O Box 4210
Helena MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 21, 2001

18. DATE APPROVED:
December 18, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Spencer K. Ericson

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: September 18, 2001

FORM HCFA-179 (07-92)

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INDEX TO NEW NURSING FACILITY MEDICAID RULE SECTIONS

INDEX TO NEW NURSING FACILITY MEDICAID RULE SECTIONS

37.40.301 SCOPE, APPLICABILITY AND PURPOSE (1) This subchapter specifies requirements applicable to provision of and reimbursement for medicaid nursing facility services, including intermediate care facility services for the mentally retarded. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) These rules are subject to the provisions of any conflicting federal statute, regulation or policy, whether now in existence or hereafter enacted or adopted.

(3) Unless otherwise provided in these rules, this subchapter applies to rate years beginning on or after July 1, 1991. Reimbursement and other substantive nursing facility requirements for earlier periods are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

37.40.302 DEFINITIONS Unless the context requires otherwise in this subchapter, the following definitions apply:

(1) "Abstracts" mean patient assessment abstracts submitted by providers to the department in accordance with the rules in effect for state fiscal year 1999.

(2) "Administrator" means the person licensed by the state, including an owner, salaried employee, or other provider, with daily responsibility for operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be a person other than the titled administrator of the facility if such person has daily responsibility for operation of the nursing facility and is currently licensed by the state as a nursing home administrator.

(3) "Case mix index (CMI)" means an assigned weight or numeric score assigned to each RUG-III grouping which reflects the relative resources predicted to provide care to nursing facility residents.

(4) "Department" means the Montana department of public health and human services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review.

(5) "Department audit staff" and "audit staff" mean personnel directly employed by the department or any of the department's contracted audit personnel or organizations.

(6) "Estimated economic life" means the estimated remaining

period during which property is expected to be economically usable by one or more users, with normal repairs and maintenance, for the purpose for which it was intended when built.

(7) "Extensive remodeling" means a renovation or refurbishing of all or part of a provider's physical facility, in accordance with certificate of need requirements, when the project's total cost depreciable under generally acceptable accounting principles exceeds, in a 12 month period, $2,400 times the number of total licensed nursing facility beds in the facility. "Extensive remodeling" does not include the construction of additional new beds, but may include construction of additional square feet or conversion of existing hospital beds to nursing facility beds if the cost requirements of this definition are met.

(8) "Fiscal year" and "fiscal reporting period" both mean the provider's internal revenue tax year.

(9) "Licensed to non-licensed ratio" means the ratio computed when the sum of all hourly registered and licensed practical nurse wages, paid or accrued by all providers, divided by the total number of registered and licensed practical nurse hours, is divided by the sum of all hourly nurse aide wages, paid or accrued by all providers divided by the total number of nurse aide hours.

(a) The licensed to non-licensed ratio will be computed using information from the most recent cost report on file as of April 1 immediately prior to the rate year, or if the hourly component of such information is not available from the cost report, from the staffing reports filed pursuant to ARM 37.40.315 for the period corresponding to the cost report period from which wage information is used to set the ratio. If the necessary information for a particular facility is not available from a cost report and/or staffing report, the wages, benefits and hours from that facility will not be used to set the ratio.

(10) "Maintenance therapy and rehabilitation services" mean repetitive services required to maintain functions which do not involve complex and sophisticated therapy procedures or the judgment and skill of a qualified therapist and without the expectation of significant progress.

(11) "Medicaid recipient" means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(12) "Minimum data set (MDS)" means the assessment form approved by the health care financing administration (HCFA), and designated by the department to satisfy conditions of participation in the medicaid and medicare programs.

(13) "Minimum data set RUG-III quarterly assessment form" means the three page quarterly, optional version for RUG-III 1997

update.

(14) "Nonemergency routine transportation" means transportation for routine activities, such as outings scheduled by the facility, nonemergency visits to physicians, dentists, optometrists or other medical providers. This definition includes such transportation when it is provided within 20 miles of the facility.

(15) "Nursing facility services" means nursing facility services provided in accordance with 42 CFR, part 483, subpart B, or intermediate care facility services for the mentally retarded provided in accordance with 42 CFR, part 483, subpart I. The department hereby adopts and incorporates herein by reference 42 CFR, part 483, subparts B and I, which define the participation requirements for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) providers, copies of which may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. The term "nursing facility services" includes the term "long term care facility services". Nursing facility services include, but are not limited to, a medically necessary room, dietary services including dietary supplements used for tube feeding or oral feeding such as high nitrogen diet, nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Payment for the services listed in this subsection is included in the per diem rate determined by the department under ARM 37.40.307 or 37.40.336 and no additional reimbursement is provided for such services. Nursing facility services include but are not limited to the following or any similar items:

(a) all general nursing services, including but not limited to administration of oxygen and medications, handfeeding, incontinence care, tray service, nursing rehabilitation services, enemas, and routine pressure sore/decubitis treatment;

(b) services necessary to provide for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life;

(c) services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each medicaid recipient who is a resident in the facility;

(d) items furnished routinely to all residents without charge, such as resident gowns, water pitchers, basins and bed pans;

(e) items routinely provided to residents including but not limited to:

(i) anti-bacterial/bacteriostatic solutions, including betadine, hydrogen peroxide, 70% alcohol, merthiolate, zepherin solution;

(ii) cotton;
(iii) denture cups;
(iv) deodorizers (room-type);
(v) distilled water;
(vi) enema equipment and/or solutions;
(vii) facial tissues and paper toweling;
(viii) finger cots;
(ix) first aid supplies;
(x) foot soaks;
(xi) gloves (sterile and unsterile);
(xii) hot water bottles;
(xiii) hypodermic needles (disposable and non-disposable);
(xiv) ice bags;
(xv) incontinence pads;
(xvi) linens for bed and bathing;
(xvii) lotions (for general skin care);
(xviii) medication - dispensing cups and envelopes;
(xix) ointments for general protective skin care;
(xx) ointments (anti-bacterial);
(xxi) personal hygiene items and services, including but not limited to:
(A) bathing items and services, including but not limited to towels, washcloths and soap;
(B) hair care and hygiene items, including but not limited to shampoo, brush and comb;
(C) incontinence care and supplies appropriate for the resident's individual medical needs;
(D) miscellaneous items and services, including but not limited to cotton balls and swabs, deodorant, hospital gowns, sanitary napkins and related supplies, and tissues;
(E) nail care and hygiene items;
(F) shaving items, including but not limited to razors and shaving creme;
(G) skin care and hygiene items, including but not limited to bath soap, moisturizing lotion, and disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection; and
(H) tooth and denture care items and services, including but not limited to toothpaste, toothbrush, floss, denture cleaner and adhesive;
(xxii) safety pins;
(xxiii) sterile water and normal saline for irrigating;
(xxiv) sheepskins and other fleece-type pads;
(xxv) soaps (hand or bacteriostatic);
(xxvi) supplies necessary to maintain infection control, including those required for isolation-type services;
(xxvii) surgical dressings;

(xxviii) surgical tape;
(xxix) over-the-counter drugs (or their equivalents), including but not limited to:
(A) acetaminophen (regular and extra-strength);
(B) aspirin (regular and extra-strength);
(C) cough syrups;
(D) specific therapeutic classes D4B (antacids), D6S (laxatives and cathartics) and Q3S (laxatives, local/rectal) including but not limited to:
(I) milk of magnesia;
(II) mineral oil;
(III) suppositories for evacuation (dulcolax and glycerine);
(IV) maalox; and
(V) mylanta;
(E) nasal decongestants and antihistamines;
(xxx) straw/tubes for drinking;
(xxxi) suture removal kits;
(xxxii) swabs (including alcohol swab);
(xxxiii) syringes (disposable or non-disposable hypodermic; insulin; irrigating);
(xxxiv) thermometers, clinical;
(xxxv) tongue blades;
(xxxvi) water pitchers;
(xxxvii) waste bags;
(xxxviii) wound-cleansing beads or paste;
(f) items used by individual residents which are reusable and expected to be available, including but not limited to:
(i) bathtub accessories (seat, stool, rail);
(ii) beds, mattresses, and bedside furniture;
(iii) bedboards, foot boards, cradles;
(iv) bedside equipment, including bedpans, urinals, emesis basins, water pitchers, serving trays;
(v) bedside safety rails;
(vi) blood-glucose testing equipment;
(vii) blood pressure equipment, including stethoscope;
(viii) canes, crutches;
(ix) cervical collars;
(x) commode chairs;
(xi) enteral feeding pumps;
(xii) geriatric chairs;
(xiii) heat lamps, including infrared lamps;
(xiv) humidifiers;
(xv) isolation cart;
(xvi) IV poles;
(xvii) mattress (foam-type and water);
(xviii) patient lift apparatus;

(xix) physical examination equipment;
(xx) postural drainage board;
(xxi) room (private or double occupancy as provided in ARM 37.40.331);
(xxii) raised toilet seat;
(xxiii) sitz baths;
(xxiv) suction machines;
(xxv) tourniquets;
(xxvi) traction equipment;
(xxvii) trapeze bars;
(xxviii) vaporizers, steam-type;
(xxix) walkers (regular and wheeled);
(xxx) wheelchairs (standard);
(xxxi) whirlpool bath;

(g) laundry services whether provided by the facility or by a hired firm, except for residents' personal clothing which is dry cleaned outside of the facility; and

(h) nonemergency routine transportation as defined in (14).

(16) "Patient contribution" means the total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with applicable eligibility rules.

(17) "Patient day" means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, such day will be considered a patient day. When department rules provide for the reservation of a bed for a resident who takes a temporary leave from a provider to be hospitalized or make a home visit, such whole 24-hour periods of absence will be considered patient days.

(18) "Provider" means any person, agency, corporation, partnership or other entity that, under a written agreement with the department, furnishes nursing facility services to medicaid recipients.

(19) "Rate year" means a 12-month period beginning July 1. For example, rate year 1995 means a period corresponding to the state fiscal year July 1, 1994 through June 30, 1995.

(20) "Resident" means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

(21) "RUG-III" means resource utilization group, version III.

(22) "RUG-III grouper version" means the resource utilization group version III algorithm that classifies residents based upon diagnosis, services provided and functional status

using MDS assessment information for each resident.

(23) "Total allowable remodeling costs" means those remodeling costs which are supported by adequate documentation. These costs include, but are not limited to, all costs of construction. These costs do not include costs of moveable equipment, supplies, furniture, appliances or other similar items. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93, (14)(e) Eff. 10/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 76, Eff. 1/17/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01)

37.40.306 PROVIDER PARTICIPATION AND TERMINATION REQUIREMENTS (1) Nursing facility service providers, as a condition of participation in the Montana medicaid program must meet the following requirements:

(a) comply with and agree to be bound by all laws, rules, regulations and policies generally applicable to medicaid providers, including but not limited to the provisions of ARM 37.85.401, 37.85.402, 37.85.406, 37.85.407, 37.85.410, 37.85.414, and 37.85.415;

(b) maintain a current license issued by the department of public health and human services under Montana law for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain a current license under the laws of the state in which the facility is located for the category and level of nursing facility care being provided;

(c) maintain a current certification for Montana medicaid issued by the department of public health and human services under applicable state and federal laws, rules, regulations and policies for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain current medicaid certification in the state in which the facility is located for the category and level of nursing facility care being provided;

(d) maintain a current agreement with the department to provide the level of care for which payment is being made, or, if the facility is located outside the state of Montana, comply with the provisions of ARM 37.40.337;

(e) operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules or policies may require;

(f) for providers maintaining resident trust accounts,

insure that any funds maintained in such accounts are used only for those purposes for which the resident, legal guardian, or personal representative of the resident has given written authorization. The provider must maintain personal funds in excess of $50 in an interest bearing account and must credit all interest earned to the resident's account. Resident's personal funds in amounts up to $50 must be maintained in such a manner that the resident has convenient access to such funds within a reasonable time upon request. A provider may not borrow funds from such accounts or commingle resident and facility funds for any purpose;

(g) A provider holding personal funds of a deceased nursing facility resident who received medicaid benefits at any time shall, within 30 days following the resident's death, pay those funds as provided by law and regulation.

(h) maintain admission policies which do not discriminate on the basis of diagnosis or handicap, and which meet the requirements of all federal and state laws prohibiting discrimination against the handicapped, including persons infected with acquired immunity deficiency syndrome/human immunodeficiency virus (AIDS/HIV);

(i) comply with ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120 and 37.40.201 through 37.40.207, regarding screening for nursing facility services;

(j) comply with all applicable federal and state laws, rules, regulations and policies regarding nursing facilities at the times and in the manner required therein, including but not limited to 42 USC 1396r(b)(5) and 1396r(c) (1994 supp.) and implementing regulations, which contain federal requirements relating to nursing home reform. The department hereby adopts and incorporates herein by reference 42 USC 1396r(b)(5) and 1396r(c). A copy of these statutes may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(2) A provider which fails to meet any of the requirements of this rule may be denied medicaid payments, refused further participation in the medicaid program or otherwise sanctioned or made subject to appropriate department action, according to applicable laws, rules, regulations or policies.

(a) Subject to applicable federal law and regulations, the department may impose a sanction or take other action against a provider that is not in compliance with federal medicaid participation requirements. Department sanctions or actions may include imposition of any remedy or combination of remedies provided by state or federal law and regulations, including but not limited to federal regulations at 42 CFR 488, subpart F.

(3) A provider must provide the department with 30 days advance written notice of termination of participation in the medicaid program. Notice will not be effective prior to 30 calendar days following actual receipt of the notice by the department. Notice must be mailed or delivered to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) For purposes of (3), termination includes a cessation of provision of services to medicaid residents, termination of the provider's business, a change in the entity administering or managing the facility or a change in provider as defined in ARM 37.40.325.

(b) In the event that discharge or transfer planning is necessary, the provider remains responsible to provide for such planning in an orderly fashion and to care for its residents until appropriate transfers or discharges are effected, even though transfer or discharge may not have been completed prior to the facility's planned date of termination from the medicaid program.

(c) Providers terminating participation in the medicaid program must prepare and file, in accordance with applicable cost reporting rules, a close out cost report covering the period from the end of the provider's previous fiscal year through the date of termination from the program. New providers assuming operation of a facility from a terminating provider must enroll in the medicaid program in accordance with applicable rules.

(4) A provider must notify a resident or the resident's representative of a transfer or discharge as required by 42 CFR 483.12(a)(4), (5) and (6). The notice must be provided using the form prescribed by the department. In addition to the notice contents required by 42 CFR 483.12, the notice must inform the recipient of the recipient's right to a hearing, the method by which the recipient may obtain a hearing and that the recipient may represent herself or himself or may be represented by legal counsel, a relative, a friend or other spokesperson. Notice forms are available upon request from the department. Requests for notice forms may be made to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-6-108, 53-6-111, 53-6-113 and 53-6-189, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113 and 53-6-168, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.307 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a per diem rate determined in accordance with this rule, minus the amount of the medicaid recipient's patient contribution. The per diem rate shall be subject to the maximum level, if any, specified in (3) through (3)(c). Except as provided in (4) and (5), the per diem rate is the sum of the following components:

(a) an operating cost component, individually determined for each provider in accordance with ARM 37.40.313;

(b) a direct nursing personnel cost component, individually determined for each provider in accordance with ARM 37.40.314; and

(c) a calculated property cost component, individually determined for each provider in accordance with ARM 37.40.323.

(2) For purposes of (1), medicaid patient days include bed hold days to the extent allowable under ARM 37.40.338.

(3) A provider's per diem rate for rate year 1992 shall neither exceed the provider's average per diem rate, including the OBRA increment, in effect for rate year 1991 plus $8.00 per diem, nor be less than the provider's average per diem rate, including the OBRA increment, in effect for rate year 1991 plus 5.5% of such 1991 rate.

(a) A provider's per diem rate for rate year 1993 shall not exceed the provider's average per diem rate, including the OBRA increment, in effect for rate year 1992 plus $9.00 per diem.

(b) A provider's per diem rate for rate years beginning on or after July 1, 1993 shall not be subject to any minimum or maximum amount of increase from the provider's previous rate or previous average rate.

(c) A provider's per diem rate effective July 1 of the rate year and throughout the rate year shall not exceed the provider's average per diem private pay rate for a semi-private bed, plus the average cost, if any, of items separately billed to private pay residents, in effect on July 1 of the rate year as specified by the provider in the department's survey of private pay rates conducted annually between April 1 and July 1 prior to the rate year. Providers who do not respond to the department's survey by July 1 of the rate year, will be subject to withholding of their medicaid reimbursement in accordance with ARM 37.40.346. The rate specified by the provider in this survey will be referred to as the reported rate.

(i) Upon request, providers must provide the department or its agents with records and information regarding the private pay rates charged to residents. If the department determines after

desk review or audit that the provider has decreased the reported private pay rate or that the provider has in fact customarily charged private paying residents less than the reported rate, the department will decrease the provider's medicaid per diem rate, retroactive to July 1 of the rate year, to the amount of the decreased or actual private pay rate customarily charged to private paying residents during the rate year. The department will decrease the medicaid rate only if the decreased amount of the average private pay rate and separately billed items is lower than the computed medicaid rate. Any overpayment will be collected as provided in ARM 37.40.347.

(ii) The medicaid per diem rate will not be increased as a result of increases in private pay rates from the private pay rate in effect on July 1 of the rate year as specified in the department's survey described in (c).

(4) A provider's per diem rate effective for the rate period July 1, 2000 through June 30, 2001 shall be determined in accordance with this rule.

(a) For each nursing facility provider, the rate as computed and in effect on June 30, 2000 shall be increased by $.50 per day effective July 1, 2000.

(b) Any nursing facility provider whose computed payment rate inclusive of the $.50 per day amount provided for in (a), is less than the computed statewide median rate inclusive of the $.50 per day amount, will be entitled to receive additional reimbursement to bring the computed medicaid per diem payment rate closer to the statewide median rate. This additional reimbursement will be computed as follows:

(i) The total dollar difference between the facility's computed rate per day and the statewide median rate per day will be computed by subtracting the facility rate from the statewide median rate.

(ii) The per day rate difference for each facility, computed in (4)(b)(i) will be multiplied by each facility's projected medicaid days for fiscal year 2001, based upon the previous fiscal years utilization experience, to determine the full amount of funding required to reimburse each facility up to the statewide median level.

(iii) The percentage of the funding that will be paid to each facility will be determined by dividing the total medicaid funding allocated for this purpose, by the total dollars that would be required to bring all facilities up to the statewide median level of reimbursement as computed in (4)(b)(ii).

(iv) The percentage that is computed above will be applied to the difference in each facility's per diem rate when compared to the statewide median rate to determine each facility's per day proportional share of the appropriated funding allocated for this

purpose.

(c) The total payment rate available for the period July 1, 2000 through June 30, 2001 will be the rate as computed in (4)(a), plus any additional amount computed in (4)(b) plus the direct care wage and benefits increase as provided in ARM 37.40.361 plus any additional amount computed in ARM 37.40.311 for qualified county funded rural nursing facilities.

(5) Effective July 1, 2001, nursing facilities will be reimbursed using a price-base reimbursement methodology. The rate for each facility will be determined using the operating component defined in (5)(a) and the direct resident care component defined in (5)(b):

(a) The operating component is the same per diem for each nursing facility. It is set at 80% of the statewide price for nursing facility services.

(b) The direct resident care component of each facility's rate is 20% of the overall statewide price for nursing facility services. It is adjusted for the acuity of the medicaid residents served in each facility. The acuity adjustment increases or decreases the direct resident care component in proportion to the relationship between each facility's medicaid average case mix index and the statewide average medicaid case mix index.

(i) The medicaid average case mix index for each facility to be used in rate setting will be the simple average of each facility's four medicaid case mix indices calculated for the periods of February 1 of the current year and November 1, August 1 and May 1 of the year immediately preceding the current year. The statewide average medicaid case mix index will be the weighted average of each facility's 4 quarter average medicaid case mix index to be used in rate setting.

(c) The rate setting methodology effective July 1, 2001, will hold nursing facilities harmless. To the extent that a provider's rate could decrease using the price-based reimbursement methodology described in this rule, each facility will receive the greater of their price-based rate or their rate in effect on June 30, 2001 increased by 2%. This hold harmless methodology, which provides for a minimum 2% rate increase each state fiscal year, will be in effect for state fiscal years 2002 and 2003. For state fiscal year 2004, or at such time as all facilities have moved to the price, each facility will be reimbursed according to the price-based nursing facility reimbursement system.

(d) The statewide price for nursing facility services will be determined each year though a public process. Factors that could be considered in the establishment of this price include the cost of providing nursing facility services, medicaid